

Jo Saint-George Phone: 602-326-8663 Fax: (202) 830-2005 E-mail: jo@woc4equaljustice.org

VIA- ECF -

October 16, 2024

Honorable Eric Komitee **United States District Court** Eastern District of New York 225 Cadman Plaza East, Courtroom 6G North Brooklyn, New York 11201

Re:

LETTER MOTION – REQUEST FOR CONTINUANCE Women of Color for Equal Justice et al. v. New York, et. al Civil Action No: 22-cv-02234

Dear Judge Komitee:

On September 25, 2024, this Court dismissed Plaintiffs claims in the above referenced matter, except for the Title VII and New York City Huma Rights Act Claims for individual claimant Amoura Bryan. See ECF #99

On October 9, 2024, Defendants the City of New York and City of New York Department of Education (Collectively "City") filed a Motion to Reconsider requesting this Court to also dismiss Ms. Bryan's remaining claims. See ECF #100.

On October 10, 2024, this Court vacated the status conference hearing scheduled November 7, 2024 and orderd Plaintiff Bryan to file a Letter Responsive Motion to the City's Motion to Reconsider.

Counsel hereby requests a 90 – day continuance for Ms. Bryan to respond to the City's Motion to Reconsider. Contemporaneously filed with this Letter requesting Continuance, Counsel has filed a Motion to Withdraw as Counsel for Ms. Bryan as outlined in the Motion and supporting Declaration. See ECF #102 Ms. Bryan will need time to secure new counsel. Attached hereto as Exhibit 1 is Ms. Bryan's Notice of Claim the City has once again falsely represented that Plaintiffs have failed to file.

There are no other scheduled deadlines in this case.

Respectfully Submitted,

<u>/s/ Jo Saint-George</u> Jo Saint-George



cc: Elisheva L. Rosen

Assistant Corporation Counsel Office of Hon. Sylvia O. Hinds-

Radix

The City of New York Law Department 100 Church Street New York, New York 10007

Phone: (212) 356-3522 E-mail: erosen@law.nyc.gov

EXIBIT #1



Document 104

VIA FILE UPLOAD

May 10, 2022

Brad Lander Office of the New York City Comptroller 1 Centre Street New York, NY 10007 Form Version: NYC-COMPT-BLA-LE-C4

> Notice of Claim Class Action - RULE 50 Re:

Dear Mr. Lander:

We represent the below list of New York City (the "City") employees who have been placed on "indeterminate involuntary leave without pay" for exercising their right to refuse to Covid-19 vaccine based on their First Amendment Right to refuse and based on the City's lack of authority to create the Covid-19 vaccine requirement because the authority is pre-empted by OSHA's authority to set workplace safety standards.

Therefore, this letter and the attached documents will serve as the Notice of Claims for Employment and Personal Injury Damages for City's Violations of the employees First Amendment Rights, various New York Civil Service Disciplinary Laws, Title VII Religious Harassment, the American's With Disability Act, and the New York City Human Rights Act, which provides punitive damages for the City's reckless disregard for the rights of its employees.

Attached find the following:

- 1. one (1) completed Employment and Personal Injury Claim form for all employees, and we have provided an Excel spreadsheet that contains all of the data required to be provided in the attached forms.
- 2. Spreadsheet list of employee information in support of the claim forms
- 3. Exhibit A Memorandum of Legal Causes of Action pages 1-94

List of Employees for which the Notice of Claim applies and is provided for "All similarly situated employees":

- 1. Curtis Boyce
- 2. Sara Coombs-Moreno
- 3. Elizabeth Loiacono
- 4. Jesus Coombs
- 5. Julia Harding
- 6. Angela Velez
- 7. Sancha Browne
- 8. Amoura Bryan
- 9. Ayse Ustares

Phone: 602-326-8663



- 10. Zena Wouadjou
- 11. Remo Dello Ioio
- 12. Charisse Ridulfo
- 13. Sancha Browne
- 14. Tracy-Ann Francis-Martin
- 15. Kareem Campbell
- 16. Michelle Hemmings Harrington
- 17. Mark Mayne
- 18. Carla Grant
- 19. Cassandra Chandler
- 20. Aura Moody
- 21. Suzanne Deegan
- 22. Evelyn Zapata
- 23. Christine O'Reilly
- 24. Edward Weber
- 25. Maritza Romero
- 26. Sean Milan
- 27. Sonia Hernandez
- 28. Jeffrey B. Hunter
- 29. Rasheen Odom
- 30. Maria Figaro
- 31. Sara Coombs-Moreno
- 32. Frankie Trotman
- 33. Yulonda Smith
- 34. Roseanna Mustacchia
- 35. Jessica Csepku
- 36. Natalya Hogan
- 37. Bruce Reid
- 38. Joseph Rullo
- 39. Cheryl Thompson
- 40. Dianne Baker-Pacius

If you have any questions or need additional information, please feel free to contact me on my cell number at 602-326-8663.

Sincerely,

Jo Saint-George, Esq. Jo Saint-George, Esq. Chief Legal Officer

Phone: 602-326-8663

Cased 1222:vv002334EKK-BB DoDomene82104Filedled/00/20/2Page2age 050P29ePage10950
Office of the New York City Comptroller

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

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On behalf of someone else. If on someone else's behalf, please provide the following information: Last Name: First Name: Relationship to the claimant: Claimant Information *Last Name: WOMEN OF COLOR 4 EQUAL JUSTIGNUS JO SAINT-GEORGE, ESQ. HAddress: Address 2: HAddress 2: HONIT 4077 +City: GIATHERSBURG *State: *First Name: VSTARES AYSE *AUSE *AUS	I am filing: 🗌	On behalf of myself.	Attorney is filing.		
Last Name: First Name: Relationship to the claimant: **Claimant Information *Last Name: VOMEN OF COLOR 4 EQUAL JUSTIC	П	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	n (if represente	d by attorney)
First Name: Relationship to the claimant: Claimant Information *Last Name: Warren of First Name: Address: Address 2: HAddress: Address 2: HAddress: MARYLAND *Last Name: Warren of First Name: Address 2: Will 4077 GIATHERSBURG MARYLAND *Zip Code: Tax Id: 261289930 *Address: Address: Address: Address 2: I Address: JO@WOC4EQUALJUSTICE.ORG *State: *Zip Code: *Zip Code: *Tax Id: #Zip Code: #Zip Code	_	Serial, pieuse provide the renoving illiamation.	+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTI
Relationship to the claimant: Address 2: +City: GIATHERSBURG Claimant Information *Last Name: USTARES *First Name: Address: Address: Address: Address: Address: Address: Address: Address: Address: *E: *City: *Eigh Code: *City: *Zip Code: *Zip Code: *Tax Id: *City:			+Firm or First Name:	JO SAINT-GEO	ORGE, ESQ.
the claimant: Address 2: +City: GIATHERSBURG Claimant Information *Last Name: USTARES 4YSE *Address: Address 2:			+Address:	MAILING - 350	E. DIAMOND AVE.
Claimant Information + State: *Last Name: USTARES *First Name: AYSE *Address: Address 2: *City: *Zip Code: *Zip Code: #Zip Code:	the claimant:		Address 2:	UNIT 4077	
*Last Name: USTARES +Zip Code: 20877 *First Name: AYSE Tax Id: 261289930 *Address: e: (602) 326-8663 Address 2: I Address: JO@WOC4EQUALJUSTICE.ORG *City: be Email: JO@WOC4EQUALJUSTICE.ORG *State: *Zip Code: ne and place where the claim arose			+City:	GIATHERSBU	RG
*First Name: AYSE Tax Id: 261289930 *Address: Address 2: I Address: JO@WOC4EQUALJUSTICE.ORG *City: De Email: JO@WOC4EQUALJUSTICE.ORG *State: *Zip Code: me and place where the claim arose	Claimant Infor	rmation	+State:	MARYLAND	
*Address: Address 2: *City: *State: *Zip Code: *Address: #Address: #E: #Address: #E: #Address: #I Address: #O@WOC4EQUALJUSTICE.ORG #O@WOC4EQUALJUSTICE.ORG #O@WOC4EQUALJUSTICE.ORG #O@WOC4EQUALJUSTICE.ORG #O@WOC4EQUALJUSTICE.ORG ### The state of the claim arose	*Last Name:	USTARES	+Zip Code:	20877	
Address 2: *City: *State: *Zip Code: *Diagram (SOZ) 626 6366 JO@WOC4EQUALJUSTICE.ORG JO@WOC4EQUALJUSTICE.ORG *Me and place where the claim arose	*First Name:	AYSE	Tax Id:	261289930]
*City: *State: *Zip Code: *De Email: JO@WOC4EQUALJUSTICE.ORG me and place where the claim arose	*Address:		e:	(602) 326-8663	
*State: *Zip Code: me and place where the claim arose	Address 2:		l Address:	JO@WOC4EQ	UALJUSTICE.ORG
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ent Date from: 09/09/2021 Format: MM/DD/YYYY	*Country:		ant Date from:	00/00/2021	Format: MM/DD/YYYY
Date of Birth:	Date of Birth:				Format: MM/DD/YYYY
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*Phone: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS	*Phone:		me Location.		
*Email Address SS: PS 19 JUDITH K. WEISS	*Email Address		:2.		
*Retype Email: ss 2:	*Retype Email:			F 3 19 30DITT	N. WLIGG
Occupation:	Occupation:		3 3	PRONY	
Current City	Current City	Yes No NA	State:		
Employee? State: NEW YORK Current Agency: DEPT. OF EDUCATION Borough: BRONX	' '	/: DEPT OF EDUCATION			
Gender: Male Female Other			J	2.10177	

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

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New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM% 20-WITH-EXHIBITS-FINAL-V2.PDF - CLAIMS:

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#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

#3 THE CITY ENGAGED IN DISCRIMINATORY HARASSMENT AND COERCION IN VIOLATION OF: TITLE VII, THE ADA (THE EMPLOYEES IN THE PROTECTED CLASS OF THOSE WITH A "PERCEIVED DISABILITY" DUE TO THEIR "UNVACCINATED STATUS" OR "VACCINE DEFICIENCY) AND IN VIOLATION OF THE NEW YORK CITY HUMAN RIGHTS ACT FOR THE SAME REASONS ABOVE. #4 WRONGFUL DISCIPLINE - THE CITY WRONGLY PLACED EMPLOYEES ON INVOLUNTARY INDETERMANAT LEAVE WITHOUT PAY BUT CLAIMED TO TERMINATE THEM IN VIOLATION OF CIVIL SERVICE LAWS A. EDUCATION LAW §3020 FOR ALL TENURED TEACHERS IN THE DEPARTMENT OF EDUCATION;

If you need additional room, attach your description as an additional document.

*Agency:	DEPT. OF EDUCATION	Work days lost:	180
Address:	65 COURT ST.		
Address 2:	#102		
City:	BROOKLYN		
State:	NEW YORK		
Zip Code:	11201		
Were you emplo	byed by a City Contractor at the time of clair	ned occurrence?	
++Contractor N	ame:		

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caased 1222:vv0022334EKK-BB Doloumente821104Filefile0/00/20/2Page 4 of 25 P20 P20 P3 Comptroller

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Overtime:					
Compensato	ory time:				
Differential:					
Annual Leav	e/Vacation:				
Sick Leave:					
Salary:					
		Total:	0.00		
Additional (Claimed Damages MENTAL DISTRE	SS DAMAGES FOR H	ARASSMENT + CC	DERCION = 2X SALARY	Amount:
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Specify:	ATTORNEY FEES	3			
Specify:					
				Total:	
**Total Claimed			_		1

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

Amount:

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New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

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I am filing: 🗌	On behalf of myself.	Attorney is filing.		
	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	ı (if represente	ed by attorney)
Last Name:		+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTIC
First Name:		+Firm or First Name:	JO SAINT-GE	ORGE, ESQ.
Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:		Address 2:	UNIT 4077	
		+City:	GIATHERSBU	RG
Claimant Infor	mation	+State:	MARYLAND	
*Last Name:	MOODY	+Zip Code:	20877	
*First Name:	AURA	Tax Id:	261289930	
*Address:		+Phone:	(602) 326-866	3
Address 2:		+Email Address:	JO@WOC4E0	QUALJUSTICE.ORG
*City:		+Retype Email:	JO@WOC4E0	QUALJUSTICE.ORG
*State:				
*Zip Code:		The time and place w	here the claim	arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
Soc. Sec #:		*Incident Location:	ONGOING RE	LIGIOUS & DISABILITY
*Phone:				T & DISTRESS
*Email Address:		Address:	65 COURT ST	REET
*Retype Email: Occupation:		Address 2:		
·		City:	BROOKLYN	
Current City Employee?	Yes ☐ No ☐ NA	State:	NEW YORK	
Current Agency	DEPT. OF EDUCATION	Borough:	BROOKLYN (I	KINGS)

Female

☐ Other

☐ Male

Gender:

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New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

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If you need additional room, attach your description as an additional document.

*Agency:	DEPT. OF EDUCATION	Work days lost:	210
Address:	65 COURT ST.		
Address 2:	#102		
City:	BROOKLYN		
State:	NEW YORK		
Zip Code:	11201		
Were you emplo	yed by a City Contractor at the time of claime	d occurrence? Yes N	No
++Contractor N	ame:		

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

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New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

		Date From:	Date 10:	Amount:		
Overtime:					\neg	
Compensato	ry time:				٦	
Differential:					٦	
Annual Leave	e/Vacation:					
Sick Leave:						
Salary:						
			Total:	0.00	7	
Additional (Claimed Damages					Amount:
Specify:	MENTAL DISTRE	SS DAMAGES	S FOR HA	ARASSMENT + COE	RCION = 2X SALARY	
Specify:	PUNITIVE DAMA	GES FOR RE	CKLESS I	DISREGARD FOR M	Y MEDICAL FREEDON	A]
Specify:	PUNITIVES CALC	CULATED BAS	SED ON 5	X GROSS SALARY		
Specify:	ATTORNEY FEES	3				7
Specify:						1
					Total:	
**Total Claimed				1		

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Amount:

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Office of the New York City Comptroller

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007 FormVersion: NYC-COMPT-BLA-LE-C4

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	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	n (if represente	d by attorney)
Last Name:	preuse previde the renewing information.	+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTI
		+Firm or First Name:	JO SAINT-GE	ORGE, ESQ.
First Name: Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:		Address 2:	UNIT 4077	
		+City:	GIATHERSBU	RG
Claimant Infor	mation	+State:	MARYLAND	
*Last Name:	BOYCE	+Zip Code:	20877	
*First Name:	CURTIS	Tax I d:	261289930	
*Address:		+Phone:	(602) 326-8663	3
Address 2:		+Email Address:	JO@WOC4EG	UALJUSTICE.ORG
*City:		+Retype Emai l :	JO@WOC4EG	UALJUSTICE.ORG
*State:				
*Zip Code:		The time and place v	vhere the claim	arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
Soc. Sec #:		*Incident Location:		
*Phone:		incident Location.		LIGIOUS & DISABILITY T & DISTRESS
*Email Address		Address:		
*Retype Emai l :			11625 GUY R.	BREVVER RD
Occupation:		Address 2:		
Current City	■ Yes □ No □ NA	City:	JAMAICA	
Employee?		State:	NEW YORK	
Current Agency	DEPT. OF EDUCATION	Borough:	QUEENS	
Gender:	☐ Ma l e ■ Female ☐ Other			

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

Casse 11 2222-0x 402223344 EEKK-LLBB Dobtournemetro22-0.4 File ideb 0 1007 1257 2 4P age age f 125 of age IT 25 of age IT

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

DEDT OF EDUCATION

Agency.	DEPT. OF EDUCATION	Work days lost.	1210 I	
Address:	65 COURT ST.	Amount Earned Week l y:		
Address 2:	#102	Amount Earned Yearly:		
City:	BROOKLYN			
State:	NEW YORK			
Zip Code:	11201			
Were you emp l o ++Contractor N	yed by a City Contractor at the time of clair	med occurrence? Yes No		

Morle days lost

* 1 0000"

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caased 1222:vv0022334EKK-BB Dobomene821104Filefile6/00/20/2@age 10:01259 29 Page 10:0588

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Total:

Salary/Benefit Claimed Damages

Overtime:

**Total Claimed Amount:

Compensatory time:

Differentia l :					
Annual Leav	/e/Vacation:				
Sick Leave:					
Salary:					
			Total:	0.00	
Additional	Claimed Damages				Amount:
Specify:	MENTAL DISTRES	SS DAMAGE	S FOR HAF	RASSMENT + COER	CION = 2X SALARY
Specify:	PUNITIVE DAMAG	ES FOR RE	CKLESS DI	SREGARD FOR MY	MEDICAL FREEDOM
Specify:	PUNITIVES CALC	JLATED BA	SED ON 3 X	GROSS SALARY	_
Specify:	ATTORNEY FEES				
Specify:					

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

^{*}Denotes field that is required.

^{**}Total Claimed Amount will be automatically calculated after all required fields are entered.

Caase 1222-v-0022334EKK-BB Dobomene 82104 File 6/00/20/21/21/22 Page 1255 P20 Page 10.959
Office of the New York City Comptroller

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

For most claims, electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

I am filing: 🗌	On behalf of myself.	Attorney is filing.		
	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	n (if represente	d by attorney)
Last Name:		+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTI <mark>C</mark>
First Name:		+Firm or First Name:	JO SAINT-GEO	RGE, ESQ.
Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:		Address 2:	UNIT 4077	
		+City:	GIATHERSBUR	RG
Claimant Infor	mation	+State:	MARYLAND	
*Last Name:	BRYAN	+Zip Code:	20877	
*First Name:	AMOURA	Tax Id:	261289930	
*Address:		+Phone:	(602) 326-8663	
Address 2:		+Email Address:	JO@WOC4EQ	UALJUSTICE.ORG
*City:		+Retype Email:	JO@WOC4EQ	UALJUSTICE.ORG
*State:				
*Zip Code:		The time and place v	where the claim	arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
Soc. Sec #: *Phone:		*Incident Location:	ONGOING REL	LIGIOUS & DISABILITY
*Email Address:		Address:	65 COURT STE	REET
*Retype Email:		Address 2:		
Occupation:	TEACHER REMOTE HOME	City:	BROOKLYN	
Current City Employee?	Yes No NA	State:	NEW YORK	
Current Agency	DEPT. OF EDUCATION	Borough:	BROOKLYN (K	INGS)

Female

☐ Other

☐ Male

Gender:

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM% 20-WITH-EXHIBITS-FINAL-V2.PDF - CLAIMS:

#1. OSHA PRE-EMPTION OF NEW YORK CITY DEPARTMENT OF HEALTH ORDERS - THE CITY THROUGH THE DEPARTMENT OF HEALTH LACKED AUTHORITY TO ISSUE THE COVID-19 VACCINE ORDERS FROM AUGUST 2021 TO DECEMBER 2021 THAT ONLY APPLIED TO CITY EMPLOYEES. ONLY OSHA HAS AUTHORITY TO CREATE AND IMPLEMENT WORKPLACE SAFETY STANDARDS. THE ORDERS WERE NOT FOR THE GENERAL GOO, CITY FAILED TO TRAIN EMPLOYEES REGARDING ALL OSHA RISK MITIGATION CONTROLS FOR WORKPLACE SAFETY AGAINST COVID-19 - SPECIFICALLY THE RIGHT TO "REMOTE WORK" AND SAFETY EQUIPMENT - SPECIFICALLY RESPIRATORS AND POWERED AIR PURIFYING RESPIRATORS (PAPR) -

#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

#3 THE CITY ENGAGED IN DISCRIMINATORY HARASSMENT AND COERCION IN VIOLATION OF: TITLE VII, THE ADA (THE EMPLOYEES IN THE PROTECTED CLASS OF THOSE WITH A "PERCEIVED DISABILITY" DUE TO THEIR "UNVACCINATED STATUS" OR "VACCINE DEFICIENCY) AND IN VIOLATION OF THE NEW YORK CITY HUMAN RIGHTS ACT FOR THE SAME REASONS ABOVE. #4 WRONGFUL DISCIPLINE - THE CITY WRONGLY PLACED EMPLOYEES ON INVOLUNTARY INDETERMANAT LEAVE WITHOUT PAY BUT CLAIMED TO TERMINATE THEM IN VIOLATION OF CIVIL SERVICE LAWS A. EDUCATION LAW §3020 FOR ALL TENURED TEACHERS IN THE DEPARTMENT OF EDUCATION;

If you need additional room, attach your description as an additional document.

*Agency:	DEPT. OF EDUCATION				
Address:	65 COURT ST.				
Address 2:	#102				
City:	BROOKLYN				
State:	NEW YORK				
Zip Code:	<mark>11201</mark>				
Were you emplo	oyed by a City Contractor at the time of claims	ed occurrence? [□ Yes	□ No	

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caase 1222:vv002334EKK-BB Doomene82104Filed 46/00/20/2 Page 16:01.75 P29 Page 10:961

New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

	Date From:	Date To:	Amount:
Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
		Total:	0.00

Additional (Claimed Damages
Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREED
Specify:	PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY
Specify:	ATTORNEY FEES
Specify:	
	Total:
***-1-1	

**Total
Claimed
Amount:

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

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^{**}Total Claimed Amount will be automatically calculated after all required fields are entered.

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

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I am filing: 🗌	On behalf of myself.	Attorney is filing.		
	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	n (if represente	ed by attorney)
Last Name:		+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTIC
		+Firm or First Name:	JO SAINT-GE	ORGE, ESQ.
First Name: Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:		Address 2:	UNIT 4077	
		+City:	GIATHERSBU	RG
Claimant Infor	mation	+State:	MARYLAND	
*Last Name:	OREILLY	+Zip Code:	20877	
*First Name:	CHRISTINE	Tax Id:	261289930	
*Address:		+Phone:	(602) 326-866	3
Address 2:		+Email Address:	JO@WOC4E0	QUALJUSTICE.ORG
*City:		+Retype Email:	JO@WOC4E0	QUALJUSTICE.ORG
*State:				
*Zip Code:		The time and place w	here the claim	ı arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
Soc. Sec #:		*Incident Location:		
*Phone:		incident Location.		LIGIOUS & DISABILITY T & DISTRESS
*Email Addres		Address:		
*Retype Email:			60-02 60TH L/	ANE
Occupation:	TEACHER	Address 2:		
Current City	■ Yes □ No □ NA	City:	MASPETH	
Employee?		State:	NEW YORK	
Current Agency	DEPT. OF EDUCATION	Borough:	MANHATTAN	(NEW YORK)
Gender:	☐ Male ■ Female ☐ Other			

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

ිකි<mark>කෙල් 1222:vv0022334EKK-B</mark>B Do<mark>Domenteහි2110</mark>4File<mark>ਰ්l&0/00/20</mark>/2@ag**@afco125p?ageDo#10**963 Office of the New York City Comptroller

New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM% 20-WITH-EXHIBITS-FINAL-V2.PDF - CLAIMS:

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#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

NEW YORK

11201

*Agency:	DEPT. OF EDUCATION	Work days lost:	210	
Address:	65 COURT ST.	Amount Earned Weekly:		
Address 2:	#102	Amount Earned Yearly:		
City:	BROOKLYN			

Were you employed by a	☐ Yes	□ No	
++Contractor Name:			

State:

Zip Code:

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caasel 1222:vv0022334=KK-BB Dolomente821104Filefile6/00/20/2#age16e2056729e10#10964

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Overtime:					
Compensato	ory time:				
Differential:					
Annual Leave	e/Vacation:			,	
Sick Leave:					
Salary:					
		Total:	0.00		
Additional (Claimed Damages				Amount:
Specify:	MENTAL DISTRE	SS DAMAGES FOR HAF	RASSMENT + COER	CION = 2X SALARY	
Specify:	PUNITIVE DAMAG	GES FOR RECKLESS D	ISREGARD FOR MY	MEDICAL FREEDOM	
Specify:	PUNITIVES CALC	CULATED BASED ON 3 >	K GROSS SALARY		
Specify:	ATTORNEY FEES	3			
Specify:					
				Total:	-
**Total Claimed					

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

Amount:

^{*}Denotes field that is required.

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Caase 1222-v-0022334EKK-BB Dobomene 82104 File 6/00/20/21/21/21/22 Fage 17:00 Page 10:00 Find New York City Comptroller

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

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I am filing: 🗌	On behalf of myself.	Attorney is filing.		
	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	ı (if represented	l by attorney)
Last Name:		+Firm or Last Name:	WOMEN OF CO	DLOR 4 EQUAL JUSTI
First Name:		+Firm or First Name:	JO SAINT-GEO	RGE, ESQ.
Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:		Address 2:	UNIT 4077	
		+City:	GIATHERSBUF	RG
Claimant Infor	mation 	+State:	MARYLAND	
*Last Name:	CHANDLER	+Zip Code:	20877	
*First Name:	CASSANDRA	Tax Id:	261289930	
*Address:		+Phone:	(602) 326-8663	
Address 2:		+Email Address:	JO@WOC4EQUALJUSTICE.ORG	
*City:		+Retype Email:	JO@WOC4EQ	JALJUSTICE.ORG
*State:				
*Zip Code:		The time and place w	here the claim	arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth: Soc. Sec #:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
*Phone:		*Incident Location:	ONGOING REL	IGIOUS & DISABILITY & DISTRESS
*Email Address:		Address:	150 WILLIAM S	TREET
*Retype Email:		Address 2:		
Occupation:		City:	NEW YORK	
Current City Employee?	Yes No NA	State:	NEW YORK	
• •	DEPT. OF EDUCATION	Borough:	MANHATTAN (NEW YORK)

Female

☐ Other

☐ Male

Gender:

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

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If you need additional room, attach your description as an additional document.

*Agency:	ADMINISTRATION FOR CHILDREN'S SE	Work days lost:	210
Address:	66 JOHN STREET		
Address 2:	#400		
City:	NEW YORK		
State:	NEW YORK		
Zip Code:	10038		
	yed by a City Contractor at the time of claimed oc	ccurrence?	0
++Contractor N	ame:		

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

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6592
Office of the New York City Comptroller

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Overtime:					
Compensato	ory time:			1	
Differential:				1	
Annual Leav	e/Vacation:			1	
Sick Leave:					
Salary:]	
		Total:	0.00]	
Additional (Claimed Damages	SS DAMAGES FOR HAI	RASSMENT + COER	CION = 2X SAI ARY	Amount:
Specify:		GES FOR RECKLESS D			+
Specify:	PUNITIVES CALC	ULATED BASED ON 3	X GROSS SALARY		3
Specify:	ATTORNEY FEES				5
Specify:					Ţ
				Total:	6
**Total					

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

Claimed Amount:

^{*}Denotes field that is required.

^{**}Total Claimed Amount will be automatically calculated after all required fields are entered.

Caase 1222-vv002334-EKK-BB Doloomene 82104 File 61/00/20/212 Page 20 cot the New York City Comptroller

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

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I am filing: □	On behalf of myself.	Attorney is filing.		
	On behalf of someone else. If on someone else's behalf, please provide the following information:	Attorney Information	n (if represente	ed by attorney)
Last Name:		+Firm or Last Name:	WOMEN OF C	OLOR 4 EQUAL JUSTI
	NOTE: MR. DELLO IOIO HAS FILED A NOTICE	+Firm or First Name:	JO SAINT-GE	ORGE, ESQ.
First Name: Relationship to	THIS IS TO CONFIRM THAT	+Address:	MAILING - 350	E. DIAMOND AVE.
the claimant:	WE REPRSENT HIM NOW.	Address 2:	UNIT 4077	
		+City:	GIATHERSBU	RG
Claimant Infor	mation	+State:	MARYLAND	
*Last Name:	RIDULFO	+Zip Code:	20877	
*First Name:	CHARISSE	Tax Id:	261289930	
*Address:		+Phone:	(602) 326-866	3
Address 2:		+Email Address:	JO@WOC4EC	QUALJUSTICE.ORG
*City:		+Retype Email:	JO@WOC4EC	QUALJUSTICE.ORG
*State:				
*Zip Code:		The time and place w	where the claim	ı arose
*Country:		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY
Date of Birth:		*Incident Date to:	05/11/2022	Format: MM/DD/YYYY
Soc. Sec #:				
*Phone:		*Incident Location:		LIGIOUS & DISABILITY T & DISTRESS
*Email Address		Address:	3450 TREMON	
*Retype Email:		Address 2:	5430 TIVEINIOI	VI AVENUE
Occupation:		City:	DDONY	
Current City	Yes No NA	State:	BRONX NEW YORK	
Employee? Current Agency	DEPT. OF EDUCATION	Borough:	BRONX	
		<u> </u>	BITOTAL	
Gender:	☐ Male Female ☐ Other			

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

ිකි<mark>කෙල් 1222: v \0 02334EKK-B</mark>B Do**Domene මි**2 1104File**ਰ් l&d/00/20**/2 අකුළු <mark>216 02 25 වන අතර ස්11</mark>1969 Office of the New York City Comptroller

New York City Comptroller Brad Lander 1´Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM% 20-WITH-EXHIBITS-FINAL-V2.PDF - CLAIMS:

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If you need additional room, attach your description as an additional document.

*Agency:	DEPT. OF EDUCATION	Work day	ys lost:	210	
Address:	65 COURT ST.				
Address 2:	#102				
City:	BROOKLYN				
State:	NEW YORK				
Zip Code:	11201				
Were you emplo	oyed by a City Contractor at the time of clair	med occurrence?	☐ Yes ☐ No		
++Contractor N	ame:				

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caased 1222:vv002334=KK-BB Dobomene82104Filefile6/00/20/2#age286:P29F10#10970
6595
Office of the New York City Comptroller

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007 FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Overtime:								
Compensato	ory time:							
Differential:								
Annual Leav	e/Vacation:							
Sick Leave:								
Salary:								
			Total:	0.00				
Additional (Claimed Damages						Amount:	
Specify:	MENTAL DISTR	RESS DAMAGES	S FOR HA	RASSMENT +	COERCIO	N = 2X SALARY		
Specify:	PUNITIVE DAM	AGES FOR RE	CKLESS [DISREGARD F	OR MY ME	DICAL FREEDO) <u>4</u>	
Specify:	PUNITIVES CA	LCULATED BAS	SED O					
Specify:	ATTORNEY FE	ES						
Specify:								
						Total:		
**Total							•	

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

Claimed Amount:

^{*}Denotes field that is required.

^{**}Total Claimed Amount will be automatically calculated after all required fields are entered.

New York City Comptroller **Brad Lander**

1 Centre Street New York, NY 10007 FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

For most claims, electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

*First Name: *Address: Address 2: *City: *State: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Phone: *Incident Date from: *Incident Date to: *Incident Location: *Incident Location: *Incident Location: *Incident Location: *Incident Location: *Incident Soc. Sec #: *Address: *Ad	I am filing: 🗌	On behalf of myself.	Attorney is filing.			
Last Name: First Name: Relationship to the claimant: Claimant Information *Last Name: *Address 2: *First Name: *Address 2: *First Name: *Address 2: *City:			Attorney Information	on (if represented by attorney)		
First Name: Relationship to the claimant: Claimant Information *Last Name: *Address: Address: Address: Address: *First Name: *Address: *First Name: *Address: *First Name: *Address: *First Name: *Address: *Address: *First Name: *Address: *Address: *Address: Address: Address: *Address: *Address: *Address: *Address: *City: *Tax Id: *Address: *Phone: (602) 326-8663 *Address: *City: *The time and place where the claim arose *Country: Date of Birth: Soc. Sec #: *Phone: *Incident Date from: *Incident Date from: *Incident Date to: *Incident Date to: *Incident Location: Address: *Address: *Address: *Address: *Address: *Address: *Address: *Address: *The time and place where the claim arose *Incident Date from: *Incident Date to: *Incident Date to: *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS *Address: *Address: *Address: *Address: *Address: *Retype Email: Occupation: Current City Employee? *Incident City Employee? *State: NEW YORK	Last Namo:		+Firm or Last Name:	WOMEN OF CO	OLOR 4 EQUAL JUSTIC	
Relationship to the claimant: Claimant Information *Last Name: BAKER-PACIUS *First Name: *Address 2:			+Firm or First Name:	JO SAINT-GEO	RGE, ESQ.	
Address 2: UNIT 4077 Claimant Information	Relationship to		+Address:	MAILING - 350	E. DIAMOND AVE.	
*Last Name: BAKER-PACIUS	the claimant:		Address 2:	UNIT 4077		
*Last Name: BAKER-PACIUS			+City:	GIATHERSBUR	RG	
*First Name: *Address: Address 2: *City: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *Address: Tax Id: 261289930 (602) 326-8663 *D@WOC4EQUALJUSTICE.ORG JO@WOC4EQUALJUSTICE.ORG *Jo@WOC4EQUALJUSTICE.ORG *The time and place where the claim arose *Country: *Incident Date from: *Incident Date to: *Incident Date to: *OS/11/2022 *Format: MM/DD/YYYY ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS 370 WEST 120TH ST. Address 2: City: NEW YORK	Claimant Infor	mation	+State:	MARYLAND		
*Address: Address 2: +Phone: +Email Address: *City: *State: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Address Address: *Address: *Country: Date of Birth: *Country: *Incident Date from: *Incident Date to: *Incident Date to: *Incident Location: *Incident Location: Address: *Address: *Address: *Address: *Retype Email: Occupation: Current City Employee? *Yes No NA NA *State: *New YORK NEW YORK	*Last Name:	BAKER-PACIUS	+Zip Code:	20877		
Address 2: *City: *State: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *City: *Retype Email: #Email Address: #Email Address #Retype Email: Occupation: #Email Address #Retype Email: Occupation: #Email Address #Incident Date from: #Incident Location: #Email Address #Email Address #Incident Date from: #Incident Location: #Email Address #Email Address #Email Address #Email Address #Incident Date from: #Incident Location: #Email Address #Incident Date from: #Incident Date f	*First Name:		Tax Id:	261289930		
*City: *State: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *City: *Retype Email: JO@WOC4EQUALJUSTICE.ORG #Incident Date where the claim arose *Incident Date from: 09/09/2021 *Incident Date to: 05/11/2022 Format: MM/DD/YYYY Format: MM/DD/YYYY *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS Address: Address: Address: City: NEW YORK NEW YORK	*Address:		+Phone:	(602) 326-8663		
*State: *Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *Incident Date in the time and place where the claim arose The time and place where the claim arose *Incident Date from: O9/09/2021 Format: MM/DD/YYYY Format: MM/DD/YYYY *Incident Date to: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS Address: 370 WEST 120TH ST. Address 2: City: NEW YORK NEW YORK	Address 2:		+Email Address:	JO@WOC4EQ	UALJUSTICE.ORG	
*Zip Code: *Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *Zip Code: *The time and place where the claim arose *Incident Date from: 09/09/2021 Format: MM/DD/YYYY Format: MM/DD/YYYY Format: MM/DD/YYYY Address: Address: Address: City: NEW YORK NEW YORK	*City:		+Retype Email:	JO@WOC4EQ	UALJUSTICE.ORG	
*Country: Date of Birth: Soc. Sec #: *Phone: *Email Address *Retype Email: Occupation: Current City Employee? *Incident Date from: *Incident Date from: *Incident Date to: *Incident Date to: *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS Address: Address: Address 2: City: NEW YORK NEW YORK	*State:					
*Incident Date from: 09/09/2021 Format: MM/DD/YYYY *Incident Date to: 05/11/2022 Format: MM/DD/YYYY *Incident Date to: 05/11/2022 Format: MM/DD/YYYY *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS *Retype Email: Address: Address 2: City: NEW YORK Current City Employee? *Incident Date to: 05/11/2022 Format: MM/DD/YYYY *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS *Address 2: City: NEW YORK NEW YORK	*Zip Code:		The time and place w	where the claim	arose	
*Incident Date to:	•		*Incident Date from:	09/09/2021	Format: MM/DD/YYYY	
*Phone: *Email Addres *Retype Email: Occupation: Current City Employee? *Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS Address: Address 2: City: NEW YORK NEW YORK			*Incident Date to:	05/11/2022	Format: MM/DD/YYYY	
*Retype Email: Occupation: Address: Address 2: City: NEW YORK NEW YORK	*Phone:		*Incident Location:			
Occupation: Current City Employee? Address 2: City: NEW YORK NEW YORK			Address:	370 WEST 120	TH ST.	
Current City	* '		Address 2:			
Employee? State: NEW YORK	Occupation:		City:	NEW YORK		
' '	Current City Employee?	Yes No NA	State:	NEW YORK		
		DEPT. OF EDUCATION	Borough:	MANHATTAN (NEW YORK)	

Female

☐ Other

☐ Male

Gender:

^{*} Denotes required fields. Either a claimant or attorney email address is required.

⁺ Denotes field that is required if Attorney is filing.

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New York City Comptroller Brad Lander 1 Centre Street New York, NY 10007

FormVersion: NYC-COMPT-BLA-LE-C4

*Nature of Claim/Description of Claim

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM% 20-WITH-EXHIBITS-FINAL-V2.PDF - CLAIMS:

#1. OSHA PRE-EMPTION OF NEW YORK CITY DEPARTMENT OF HEALTH ORDERS - THE CITY THROUGH THE DEPARTMENT OF HEALTH LACKED AUTHORITY TO ISSUE THE COVID-19 VACCINE ORDERS FROM AUGUST 2021 TO DECEMBER 2021 THAT ONLY APPLIED TO CITY EMPLOYEES. ONLY OSHA HAS AUTHORITY TO CREATE AND IMPLEMENT WORKPLACE SAFETY STANDARDS. THE ORDERS WERE NOT FOR THE GENERAL GOO, CITY FAILED TO TRAIN EMPLOYEES REGARDING ALL OSHA RISK MITIGATION CONTROLS FOR WORKPLACE SAFETY AGAINST COVID-19 - SPECIFICALLY THE RIGHT TO "REMOTE WORK" AND SAFETY EQUIPMENT - SPECIFICALLY RESPIRATORS AND POWERED AIR PURIFYING RESPIRATORS (PAPR) -

#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

#3 THE CITY ENGAGED IN DISCRIMINATORY HARASSMENT AND COERCION IN VIOLATION OF: TITLE VII, THE ADA (THE EMPLOYEES IN THE PROTECTED CLASS OF THOSE WITH A "PERCEIVED DISABILITY" DUE TO THEIR "UNVACCINATED STATUS" OR "VACCINE DEFICIENCY) AND IN VIOLATION OF THE NEW YORK CITY HUMAN RIGHTS ACT FOR THE SAME REASONS ABOVE. #4 WRONGFUL DISCIPLINE - THE CITY WRONGLY PLACED EMPLOYEES ON INVOLUNTARY INDETERMANAT LEAVE WITHOUT PAY BUT CLAIMED TO TERMINATE THEM IN VIOLATION OF CIVIL SERVICE LAWS A. EDUCATION LAW §3020 FOR ALL TENURED TEACHERS IN THE DEPARTMENT OF EDUCATION;

If you need additional room, attach your description as an additional document.

*Agency:	DEPT. OF EDUCATION	Work days lost:	210	
Address:	65 COURT STREET	Amount Earned Weekly:		
Address 2:		Amount Earned Yearly:		
City:	BROOKLYN			
State:	NEW YORK			
Zip Code:	11201			
Were you empl	loyed by a City Contractor at the time o	of claimed occurrence? Yes No)	
++Contractor I	Name:			

^{*}Denotes required field

⁺⁺Denotes field that is required if you were employed by a City Contractor.

Caasel 1222: දැට022**334EKK-BB Dobomene8210**4Filefile6/00/20/2@2@age25ee295e296e109#3 Office of the New York City Co

Amount:

New York City Comptroller Brad Lander

Date From: Date To:

1 Centre Street New York, NY 10007 FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Overtime:								
Compensator	ry time:			7				
Differential:				7				
Annual Leave/Vacation:								
Sick Leave:								
Salary:								
		Total:	0.00					
Additional C	Amount:							
Specify:	MENTAL DISTRES	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY						
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM							
Specify:	PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY							
Specify:	ATTORNEY FEES							
Specify:								
				Total:				
**Total Claimed								

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

Amount:

^{*}Denotes field that is required.

^{**}Total Claimed Amount will be automatically calculated after all required fields are entered.